CHAPTER OVERVIEW

This chapter describes the process of recommending placement of a child in out-of-home care into a residential treatment facility. As in all decisions regarding the removal of children from their parents' homes, decisions must be made based on what is in the best interest of the child(ren). If it is determined residential treatment is in the best interest of the child, all treatment planning must be tied to Adoption and Safe Families Act (ASFA) goals of reunification, adoption, kinship/guardianship, or independent living, meet all ASFA guidelines, and discharge planning must begin at the time of admission.

18.1 Mandate and Rationale

The changing face of residential care for children has been swift and radical over the last several years. No longer is the population of children served only the homeless, dependent, or neglected. Seriously emotionally disturbed adolescents, children with learning difficulties, with behavioral disorders, and with developmental problems have become the standard rather than the exception. Many of the children now being cared for are often more aggressive, more assaultive, unable to function adequately within or be readily tolerated by the family, the school or the community. There are also a large and growing number (of abused and neglected children) whose environment has been detrimental to their functioning. This is due, in large part, to social and family stress and the need to enhance parental skills. Because of these different needs of children, new types of substitute care have emerged in order to respond to a variety of individual needs and requirements of children in care

Regardless of the reason a youth is in need of residential placement, the goal of all levels of treatment must be focused on stabilizing the youth's behaviors so that he/she may be able to return to the community. The return to the community may not refer to return of physical custody to the youth's parents, but must focus on a permanency plan as mandated by the Adoption and Safe Families Act. Therefore, discharge planning, or all the things that must be in place for the youth to return to the community, must be addressed at the time of placement. The placement needs must be addressed while the youth is receiving therapeutic services so that as the youth is able to change and control

his/her behaviors, appropriate resources to meet his/her needs are being developed in the local community - to support the parents or substitute family - so that his/her physical, emotional, and therapeutic needs can be met within his/her home community, and in the least restrictive placement possible.

18.2 Residential Treatment Referral (CS-9)

The CS-9 focuses on the chronicity of behavior and includes the use of Childhood Severity of Psychiatric Illness (CSPI). The CSPI is an assessment tool developed to assist in the management and planning of appropriate services for children, ages six (6) and over, and adolescents. It is a decision support tool for Children's Service Workers and clinical decision-makers. The CSPI provides for the structured assessment of children with possible mental health service needs, along a set of dimensions found to be relevant to clinical decision making. The instrument is simple to complete and interrater reliability is high. It is designed to provide information regarding children's mental health needs for utilization during service system planning and quality assurance monitoring. Its use will enhance our ability to make differential decisions regarding a child's need for residential treatment. The CSPI also serves as the eligibility determination process for youth being enrolled in the Medicaid Rehabilitation Option. This program allows The Children's Division (CD) to access federal funding to purchase rehabilitative services to meet children's identified mental health service needs.

Revisions to the CS-9 are reflective of a wider agency strategy aimed at reducing a traditional reliance on costly and protracted residential placement for children and youth. It is critical staff recognize that when youth are admitted for residential treatment, overall planning for discharge must begin at the time of admission.

NOTE: No child is to remain in residential treatment beyond six (6) months without a full review coordinated by the area director. The goal is for the child to be placed from residential treatment into a less restrictive placement setting.

Whenever possible, that setting should be with the child's family (if the child's needs can be met there) with the necessary support services being provided by community resources. Because goal setting and treatment plan development is done by the Family Support Team (FST), with input from the family, the youth, and the residential treatment facility, those service needs will be documented. Development of the resources should be accomplished while the youth and family are receiving therapeutic services provided by the residential facility.

NOTE: Placement of youth must be within a fifty (50) mile radius of their family whenever possible. When making a placement of a youth into a residential treatment facility located 50 miles or more from the county of jurisdiction, the Children's Service Worker must document that an exhaustive local search was conducted and that the child's treatment needs may not be met within the 50 mile radius. Meeting the child's special needs will take priority over placement in proximity to the parent(s) when selecting a provider, if both standards cannot be satisfied.

Placement of children in residential child-care agencies should be expected to last for only six (6) months. The Residential Care Screening Team (RCST) Coordinator must approve recommendations for extension, after review by the area director.

NOTE: A copy of any court order identifying a specific facility and payment for these services for the child's placement must be sent to the Deputy Director/Children's Services, via supervisory lines, for immediate review by the Division of Legal Services (DLS) and RCST Coordinator.

18.3 Residential Facility-Based Rehabilitative Treatment Services (REHAB-RT)

As a part of the Rehabilitative Treatment contract, the residential facility must work toward reunification of the youth with his family, another permanent family, or (if the child is to leave residential treatment to be on his own) with the youth, to establish a home for himself/herself. If the youth is to leave residential care to be independent, the facility, in cooperation with the agency, is to develop the community resources the youth will require in order to become independent.

18.4 Referral Process

If the decision is made that residential treatment can best meet the child's clinical needs, referrals to residential treatment shall follow these guidelines:

1. The case manager must assess the child's need, via completion of the "Residential Treatment Referral" (CS-9), for residential treatment services. The family, the FST, and other resources shall be utilized to assure the child's needs are addressed in the CS-9. Referrals for emergency and non-emergency residential placement must be submitted to the RCST Coordinator.

   Referrals to consider traditional foster family or kinship homes are NOT submitted to the RCST Coordinator.

   a. Determine what needs to occur to facilitate the child's return to family or to another permanent placement in the community, coordinating and planning with the parent(s), the youth, and using recommendations of the provider and the RCST Coordinator.

   b. Utilize the needs list to develop the "treatment plan" to be implemented by the case manager **and the residential treatment facility.**

   c. If it appears the child will be unable to return to family of origin, develop alternate plans using concurrent planning and meeting the ASFA requirements and mandated time lines.

d. If other services are needed, involve the Department of Mental Health (DMH): Division of Comprehensive Psychiatric Services (CPS)/Division of Mental Retardation and Developmental Disabilities (MRDD) at this time to maximize interagency expertise and financial participation.

2. The FST shall assess the child's needs and devise the treatment plan. The FST shall include the child (if age appropriate), family, juvenile court representative, Guardian Ad Litem, community representatives, the Children's Service Workers, and other members of the family's support system.

   a. Because placement should always be in the least restrictive setting, efforts should be made to place a child with a kinship home, traditional foster home, or a therapeutic foster home prior to referral to residential treatment.

   b. Collateral documentation of behavior or other factors that indicate a need for residential treatment services should be provided, before referral to residential treatment is considered.

   c. The treatment plans must include strategies to allow for the child to remain "connected" to his/her family, kin, community, etc.

   d. Connection to the community must be an integral part of the treatment plan for older youth who have a permanency plan of independent living.

   e. The case manager/worker and the FST must remain an active and viable part of treatment planning.

   f. Maintain the child in care of provider until placement with the new provider is available, if an emergency placement is not needed; or

   g. Seek other resources for placement until the RCST Coordinator reaches a decision that residential treatment services are appropriate and available.

3. Submit the following materials to the RCST Coordinator when the child has met the above criteria. The family, community members, or others who know the child can help with providing this material.

   a. Completed CS-9 that includes the CSPI.

   b. Social history or psychosocial assessment or court assessment completed within last 60 days.

   c. Current case plan (CS-1).

d. Current school report/grade level and any applicable records. For children with special education requirements, current Individualized Education Plan (IEP) and educational diagnostic assessment.

e. Medical history.

f. Copy of parent's service agreement.

g. Immunization record.

h. Court orders and petitions.

i. Criminal history.

j. Psychological/psychiatric evaluation

k. Copy of birth certificate or number

l. For any youth age 16 and over, include CS-3 Life Skills Inventory, Daniel Memorial Life Skills Inventory, or CS-1 Attachment.

4. Submit the CS-9 to the RCST Coordinator if it appears residential treatment services will best meet the child's clinical needs. The Case manager, supervisor, and RCST Coordinator will share information about the referral, discussion of possible placement resources, the urgency of need for placement, and other relevant information.

NOTE: The RCST Coordinator will determine the most appropriate residential childcare agency, treatment period and placement date, authorizing all items on the CS-67A.

5. Receive notification from the RCST Coordinator regarding appropriateness of referral for placement, and receive copies of the RCST Coordinator's written request for admission/placements to appropriate providers.

6. Carry out any of the following actions as appropriate to the RCST Coordinator's decision or recommendations.

a. Advise court and develop alternative treatment and/or case plan if referral is determined inappropriate or if other options besides residential placements have been suggested.

b. Coordinate all planning if county of current placement is different from county of jurisdiction.

c. Receive notification from the RCST Coordinator when a resource becomes available if child has not yet been accepted in an appropriate placement.

d. Notify the RCST Coordinator in writing if placement is no longer needed.

NOTE: Written notification should be made in all instances of placement or withdrawal of placement request.

7. Receive notification from provider of date for pre-placement interview visit.

8. Proceed with placement preparation including the following:

   a. Prepare child and parents for change in placement. Provide information about the facility, location, special programs, visitation arrangements, etc.

   b. Assess clothing needs and seek approval for expenditure if clothing is needed.

   c. Arrange dental and medical examination within 30 days prior to actual placement, if provider requires more recent medical report.

9. Assure child's arrival at facility on date arranged for entry.

NOTE: At time of placement, all case plan responsibilities revert to the Children's Service Worker in the county of jurisdiction if child had been placed in another county.

10. Update the SS-61 to denote new placement and CSPI scores.

NOTE: For children entering emergency residential placement, the CS-9, including the CSPI shall be completed within five (5) working days and submitted to the RCST Coordinator. In addition, the SS-61 will be updated with the CSPI scores.

   a. Complete the CS-65 if any special expenses are needed, have been approved, and are not included in the residential treatment contract.

   b. Update the SS-61 to delete maintenance for any child entering a residential child care agency.

11. Provide any needed placement support services consistent with the Case Plan (CS-1) including services to the parents.

   a. Receive progress reports from provider. The initial evaluation and plan of care should be in compliance with the FST plan, or if different, the reasons for any change must be documented.

b. Determine what needs to occur to facilitate the child's return to family or to another permanent placement in the community, coordinating and planning with the parent(s) and using recommendations of provider and the RCST Coordinator.

c. Submit copy of Case Plan (CS-1), including Family Support Team (FST) recommendations, to the RCST Coordinator at intervals required for each form.

NOTE: Representatives of the treatment provider must be invited to attend the FST meeting. The treatment facility staffing can be combined with FST when appropriate as treatment goals, modality, and progress of child and family should be relevant discussion for members of both groups. Often the team members are the same for both meetings.

d. Submit reports to court at required intervals incorporating progress reports, and the case Plan (CS-1) including the FST and the treatment plan as determined by the FST. This should be the same treatment plan as that determined by the residential treatment facility.

e. Submit copy of report to assigned Court Appointed Special Advocate (CASA) volunteer, if applicable.

f. Maintain responsibility for case record and case action including FSTs.

g. Notify local law enforcement agency or Missouri Highway Patrol immediately if child is reported as a runaway.

h. Notify RCST Coordinator in writing, immediately, of any child removed from an authorized placement. Include date of discharge and identification of present placement resource.

12. Inform the RCST Coordinator, in writing, of any additional service needs the child may require. Include information describing the child's actual needs requiring a service outside of those provided by the residential child care agency. Indicate the reasons as stated by the agency that they are unable to provide these services. The RCST Coordinator will determine if these services are excluded from the contract with the facility.

13. Integrate content of progress reports into services to the parents, FSTs, case plan development, reports to Court, etc. The family may be included in therapeutic services provided to the child. The Rehabilitation contract requires the facility to provide rehabilitative services, encourage visitation with the family, and work toward reunification of the family members.

14. Receive written notification from the RCST Coordinator at least 60 days prior to expiration date of treatment authorization.

15. Receive notification from the provider at least 30 days prior to planned discharge of the child. If the FST has determined that the child and family are to be reunited, this plan shall be put into place. The residential facility, through therapeutic intervention with the youth and family, as well as working with the assigned case manager, shall identify necessary systems to support the family and youth during reunification. The case manager and other members of the FST will assure these supports are available to the family and youth as the goal of reunification is put into place.
    If the FST determines that the youth's needs cannot be met in the community and that return to the family or to another family setting - such as a therapeutic foster family, is not appropriate, the FST shall recommend that the child remain in a residential setting. If this is the case, the case manager will:

    a. Submit recommendations to the RCST Coordinator regarding child's continued need for treatment as soon as possible.

    b. Send copy of notification to service county, if different from the county of jurisdiction.

16. The case-manager shall continue to determine what needs to occur to facilitate the child's return to family or to another permanent placement in the community, coordinating and planning with the parent(s) and using recommendations of provider and the RCST Coordinator. The case manager shall continue to utilize this needs list to develop the treatment plan to be implemented by the case manager and the residential treatment facility. If it appears the child will be unable to return to family of origin, the FST, with the involvement of the child and family shall develop alternate plans for the child using concurrent planning and meeting the Court and ASFA time lines. The child and his family shall be encouraged to locate kinship placements or other permanent placements that will allow the child to remain involved with his/her family of origin, even if it is not realistic for the youth to be reunited with his/her family.

17. Provide aftercare services when the child returns to own family. If the child is unable to return to his/her family of origin, provide other replacement services, as appropriate to the child's needs and permanency plan.

18. Record all activities every 30 days, incorporating progress reports, FST meetings, and Case Plan changes as appropriate.

18.5 Residential Care Screening Team Coordinator Responsibilities

The Residential Care Screening Team (RCST) Coordinator is located in each of the seven Area Offices. His/her role is to screen and prioritize placement requests for the area, secure placements, match a child with a facility which can meet the needs of the child, and assure that the Area stays within the funds available for residential treatment services.

The RCST Coordinator has final approval/authority for all children referred and accepted for residential treatment services, and oversees modification to a child's residential treatment/service plan.

The RCST Coordinator reviews children's needs, as identified on the CS-9, to assure residential treatment will best meet the child's clinical needs. If residential treatment is not determined to be appropriate, this is discussed with the case manager and supervisor. The county staff will seek other options for treatment. As stated in other sections of this chapter and in other chapters, treatment for each child shall meet the clinical needs of that child and shall be offered in the least restrictive placement that assures safety for the child and for others.

The RCST Coordinator has responsibility to:

- Screen a referral within five (5) working days of its receipt in order to determine the treatment needs of the child.

- Make written requests to appropriate contractual providers for admission/placement.

- Notify the referring Children's Service Worker if an appropriate treatment resource is not available.

- Complete the CS-67 and enter the data indicating the child has been determined eligible and appropriate for residential treatment. Retain information about the child if no resource or funding is currently available.

- Notify the referring Children's Service Worker when a placement becomes available.

- Determine a treatment period for the child. The treatment period will be based on an assessment of the child's needs, the services supplied by the provider, and as determined by the specific contract with the provider. The treatment period will be dependent on the treatment plan as developed jointly by the FST with input from the case manager, residential treatment provider, the family, the youth, the juvenile court representative, and the Guardian ad Litem. Complete the CS-67, showing corresponding eligibility periods. Authorize services using CS-67A within the established eligibility dates.

  NOTE: Each child's placement should be reevaluated every six (6) months to determine if residential treatment continues to best meet the child's clinical needs.

- Review and approve/deny requests from the provider or the Children's Service Worker for extensions of the treatment period. Such decisions will be based on the progress reports received from the provider as well as a review of the regularly submitted CS-1 that includes the recommendations of the FST. Assure that the treatment facility is providing rehabilitative services to the child and family, including encouraging visits as a part of the therapeutic process.

- Seek a another placement resource through the "matching" process if the child continues to need residential care services and the facility currently providing care cannot meet the needs of the child.

- Review treatment and progress reports received from the provider. These should include any changes in treatment, identify the involvement with the family, progress toward reunification, and progress at "rehabilitation" of the youth for the problems for which he/she was referred to the facility.

NOTE: Providers are required to submit treatment and progress reports to the RCST Coordinator and the case manager at certain intervals. Refer to the contract under which the licensed residential child care agency operates for a description of these intervals.

- Notify the county of jurisdiction 60 days in advance of the child's planned discharge.

- Complete and enter data on the CS-67A authorizing residential treatment as necessary. Update the CS-67A to reauthorize or modify authorizations.

NOTE: The RCST Coordinator shall authorize any special expenses or services not covered by the residential treatment contract. It continues to be the responsibility of the case manager to authorize payment for special expenses via the CS-65 for children receiving residential treatment program services.

- Arrange for an evaluation of the child by the residential treatment provider so that the provider can develop a treatment plan for the child. The provider can require this evaluation be conducted in residence. If so, the provider must complete the evaluation and a recommended treatment plan within 15 days. This treatment plan must be provided to the RCST Coordinator and case manager. If the treatment plan differs from that of the FST, clear documentation of the recommended change must be provided.

- Coordinate, consult, and negotiate with the provider and the county with jurisdiction so that the objectives of the treatment plan for the specific child can be met. This treatment plan will be integrated into the comprehensive case plan (CS-1) developed with the child and family and all members of the FST during the FST meeting.

Related Subject: CS-1 and its instructions in the Children's Services Form Manual.

- Use the standards for selection of a placement resource, assuring that the child is placed in the least restrictive placement where his/her safety can be maintained. Meeting the child's special needs will take priority over the standard of placement in proximity to the parents.

Related Subject: Chapter 4.2, of this section, Guidelines for Initial Placement Resource Selection

NOTE: Family Support Teams (FSTs) are used to drive treatment planning, to determine placement goals and objectives, and to provide ongoing monitoring of progress. If the child is unable to return to the family of origin, the family and child shall both continue to be involved in planning for permanency utilizing extended family, kin, or other known resources. Staff may also contact the Residential Program Unit at 573-751-4920, for further information.

18.6 Requirements for Licensed Residential Treatment Facilities

All children in the custody of the Children's Division must be placed in a facility that has a contract with the Division for alternative care and/or residential treatment services. Referrals for residential treatment services must be made to the RCST Coordinator.

Refer to Lotus Notes Applications data base for Service Providers to access a current listing of all the child caring facilities in Missouri who have been licensed to provide treatment and 24 hour care. It is organized by the geographic location of the facility within the Division's Area administrative structure. Each facility is further described with the following data:

1. Departmental Vendor Number (DVN): A series of nine (9) numeric digits that are used in the Alternative Care Tracking System (ACTS), Children's Services Integrated Payment System (CSIPS), and Service Eligibility and Authorization System (SEAS).

2. Designation of the provider's current contract status with the Division is identified by Emergency (EMER), Family Focus (FFRT), Residential Treatment (RT), Maternity (MATR), or Maternity with Infant (MATI) services placed immediately following the DVN. Additional information related to current status of the contract can be obtained by review of the ZCVR computer screen and the DVN.

18.6.1 Levels of Care

- Emergency Shelter: This is a short-term resource for children requiring an immediate, temporary living arrangement in an open facility where their safety and supervision is ensured through an organized program of appropriate activities. This service is appropriate for children who need the following:

  - Physical maintenance services - including food, clothing, shelter, medical and dental care, nurturance and supervision;

  - Family centered services - including individual, family and group therapy for the child and/or his/her parents;

- Educational, religious, recreational, and socialization experiences according to the needs of the individual child; and,

- Joint planning between provider and Division, evaluation, implementation and review of treatment objectives, as determined by the FST.

· Moderate Need Level II: This is an extended placement resource for children requiring a planned program affording safety, structure, and supervision. This level is indicated for children who by reason of family situation, relationship problems with family, level of development and/or maladaptive behaviors are unable to accept traditional family ties and/or successfully participate in traditional family settings. Facilities that have signed a Rehabilitation Options Contract, should provide reunification services, work with the family, community based services, schools, etc. as a part of therapeutic services provided. Moderate Need Level II service is appropriate for children who need the following:

  - Physical maintenance Services - including food, clothing, shelter, medical and dental care, nurturance, and supervision;

  - Family centered services - including individual, family and group therapy for the child and/or his/her parents;

  - Educational, religious, recreational and socialization experiences according to the needs of the individual child;

  - Diagnostic assessment;

  - Adjunctive services based upon the developmental level of the child and level of need; and

  - Both individual and group counseling to the child and his parents as part of the overall treatment effort, recognizing that reunification of the child and family is the primary goal of the agency if safety of the child in that setting can be assured.

· Severe Need/Level III: This is an extended placement resource for children requiring active, coordinated, and professional intervention on a residential basis. This level is indicated for children who cannot be effectively managed in a less restrictive setting. These children exhibit a mental illness or mental disorder as diagnosed according to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV). These children have continued difficulty adjusting to an open public school setting. A CSPI shall be completed on the child by the case-manager to evaluate his/her current needs. See CS-9 instructions. Facilities that have signed a Rehabilitation Options Contract, should provide reunification services, work with the family,

community based services, schools, etc. as a part of therapeutic services provided. Severe Need service is appropriate for children who need the following:

- Physical maintenance services - including food, clothing, shelter, medical and dental care, nurturance, and supervision;

- Family centered services for the child and/or his/her parents - including individual, family and group therapy

- Educational, religious, recreational and socialization experiences according to the needs of the individual child;

- Psychological and/or psychiatric treatment services;

- Joint planning, evaluation, and implementation of treatment objective as mutually agreed upon with the FST;

- Intensive individual and group counseling, adjunctive, and supporting activities, dependent upon the child's needs while the child is in placement;

- Intensive individual and group counseling with the parents while the child is in placement; and,

- Treatment planning for aftercare services to maintain the growth achieved in residential care.

- In addition to the services required for Level III care, the appropriate services must include the following:

- Psychiatric supervision and review of child's individual treatment wherein the psychiatrist's physical contact with the child shall occur no less than once every 30 days;

- Classroom education as required by law, which shall be provided in a school located at the contractor's facility;

- Treatment services encompassing a coordinated plan, utilizing, at a minimum, group and individual therapeutic modalities consistent with the needs of the child.

· Intensive Need/Level IV: This is an extended placement resource for children requiring active, coordinated, and professional intervention in a highly structured and secure environment. Such children will have demonstrated an inability to function in any less restrictive setting. This level is indicated for

children who exhibit a severe mental illness and/or persistent mental disorder as diagnosed according to the DSM-IV. A CSPI shall be completed on the child by the case-manager to determine current needs. See CS-9 instructions. Facilities that have signed a Rehabilitation Options Contract, should provide reunification services, work with the family, community based services, schools, etc. as a part of the therapeutic services provided. These children are unable to function consistently in an open, public school setting. They present a chronic runaway risk. They also typically present a history of showing rage, including physical aggression. This service is appropriate for children who:

- Have previously received care in an acute psychiatric hospital, but are not currently in need of inpatient psychiatric treatment; or,

- Have treatment needs, which cannot be met by any of the residential care facilities contracted with the state agency to provide treatment to children with severe needs.

18.6.2 Progress Reports

Facilities under contract are required to complete a treatment plan and progress report and submit these to the Children's Service Worker and the RCST Coordinator at the following intervals:

1. A treatment plan must be developed within fifteen (15) days of the child's initial placement. Progress reports are due every ninety (90) days thereafter, as long as the child remains in placement;

2. Within thirty (30) days prior to the end of each six (6) months of the child's placement. This progress report should include a current CSPI, completed by the facility evaluating the child's current needs as differentiated from the child's needs at the time of placement; and,

3. Thirty (30) days prior to the expiration date of the child's treatment authorization or planned discharge.

Progress reports can be submitted more frequently if the individual case plan indicates that doing so would enhance services. Such reports shall contain the following information:

1. Contractor's understanding of the long range plan for the child including the tasks and goals related to the efforts at reunification;

2. Contractor's understanding of the specific goals for placement;

3. Tasks within the total plan for the child and parents as assigned by the FST should be identified specifically;

4. Of the tasks completed (assigned to contractor/child/parent(s):

    a. Are achievements documented?

    b. Have the tasks led to the desired goal?

    c. Are there child or parent strengths apparent now that were not at the time of placement?

5. Of tasks not completed (assigned to contractor/child/parent(s):

    a. Why were tasks not completed?

    b. Are failures to complete the tasks documented?

    c. Are tasks reasonable or appropriate?

6. Planned visiting between parent(s) and children:

    a. Were plans for visiting reasonable and appropriate and were they carried out?

    b. Why did visiting not occur, if applicable?

    c. Are failures to visit documented?

7. Expected length of continued placement, in months, including whether this has changed since the initial placement, and the documented reason for the child to remain in the treatment facility;

8. Identification of needed changes in the long range plan, specific tasks, or visiting schedule; and

9. Information to the payment designee as to when reports are received, so payment to provider is not interrupted.

18.7 Requirements for Licensed Child Placing Agencies

The laws of Missouri, section 210.221, RSMo, (1997) give the Children's Division responsibility for developing and issuing rules establishing standards of service for the private agencies involved in placement of children in foster care and adoption. Section 210.221, RSMo, (1997) makes it unlawful for any person to establish or operate a child placing agency without having in full force and effect a written license granted by the Division. The primary purpose of the regulations is to protect the health, safety and

welfare of children being placed outside their home and to assure accountability to at least a minimum standard of quality child placement services.

Foster care is utilized when circumstances in a child's life make temporary placement outside of their family necessary for the child's care and safety. Agencies providing such care to children have the responsibility to insure that the child receives the necessary care, protection, and services leading to a permanent plan.

Adoption is a lifelong experience that has a unique impact on all the parties involved. Society and child welfare agencies have the responsibility to assist families formed by adoption, to inform and counsel adopted adults, to assist parents in resolving grief and loss, and to provide supportive services. The public should be informed that these services exist and are available to all that need them.

Not all of the child placing agencies provide both foster care and adoption services. Several agencies provide only one of these services. Refer to Children's Services Website for Service Providers to access a current listing of all the Licensed Child Placing Agencies operating in the state. Further information concerning these agencies and the Rules for Licensing Child Placing Agencies may be obtained by contacting the Residential Program Unit at (573) 751-4920.

MEMORANDA HISTORY: